District of Columbia State Innovation Model
Care Delivery Work Group: Meeting Summary

October 15, 2015
3:00 p.m. – 4:30 p.m.

Participants present: Lisa Fitzpatrick, Shelly Ten Napel, Lara Pukatch, George McFarland, Walter Faggett, Edwin Chapman, Guadalupe Pacheco, Sharon Henry Phillip, Cyd Campbell, Leslie Lyles Smith, Brendan Sinatro, Robert Howard, Ana Veria, Mark Weissman, Victoria Roberts, Meghan Davies, Melissa McCarthy, Wes Rivers, Peter Tuths, David Tatro, Tollie Elliot, Stephanie Hafiz, Shayla Hamlin, Linda Holifield, Layo George, Erin Leveton, Abby Charles, Derdire Coleman, Janice Llanos-Velazquez, Yolanda Williams, Dena Hasan, DaShawn Groves, Chris Botts, Joe Weissfeld, An-Tsun Huang, Gwen Young

Participants present via teleconference: Andem Effiong, Janet Jones, Ramesh Balakrishnan, Alan Watson, Conrad Clyburn, Lauren Ratner, Suzanne Fenzel, Christian Barrera, Victor Freeman, Justin Goforth

TOPIC	DISCUSSION
Definition(s) of Care Coordination	• **Many different definitions of care coordination** across the city (e.g. case management, navigation, outreach); predominately consistent with proposed goal(s) of care coordination: ➢ To meet patient needs and preferences in delivery of high quality, high value healthcare ➢ Assess individual's needs and preferences ➢ Communicate needs and preferences at right time to right people ➢ Use information to guide delivery of safe, appropriate effective care • **Common characteristics of care coordination include:** ➢ Organizing patient care activities, guided by patient needs and preferences (e.g. creating

TOPIC	DISCUSSION
	treatment plans, managing care transitions, coordinating follow up visits) ➢ Sharing information among <u>all</u> care participants (e.g. instituting team-based care, ensuring coordination with other providers) ➢ Achieving safer, more effective care (e.g. providers with condition specific specialization) ➢ Improving health outcomes ➢ Navigating resources (e.g. leveraging community resources, assisting with housing, financial, insurance related issues, ensuring transportation)
<u>Vision for Care Coordination</u>	• **Health Information Exchange** ➢ Develop a platform to connect EHRs to inpatient and outpatient ➢ Share clinical information and care plans in real or near real-time ➢ Navigate social and medical data ➢ Ensure tools are user-friendly (for patient and provider) ➢ Offer risk and cost assessment tools ➢ Improve access to patient's primary care provider and/or case manager • **Outreach** ➢ Identify social determinants of health and integrate that data into clinical decisions ➢ Patient-centric approach to address barriers (e.g. health literacy, social determinants) ➢ Sustained relationships with currently unengaged patients

TOPIC	DISCUSSION

	• **Workforce**
	  ➢ More targeted/efficient use of resources and better coordination among care coordinators
	  ➢ Grow the number of providers performing at the top of their license
	  ➢ Increase provider participation in Medicaid
	• **Financing**
	  ➢ Sustainable funding sources
	  ➢ Alternative payment models
	  ➢ Reimbursement for technology enabled care coordination (e.g. telehealth)
	• **Measuring Effectiveness**
	  ➢ Integrate performance measures to identify effectiveness of interventions

<u>Health Home: Aims</u>	• Provide a sustainable care coordination benefit for beneficiaries with multiple chronic conditions • Bring consistency, alignment, and accountability to the care coordination process • Align resources with patient and population needs • Facilitate interdisciplinary work • Use health information technology and exchange to enable care coordination efforts